imMTrax Permission Form

Please Print

Child's Name:_____ Sex: M__ F__ Date of Birth:_____

Address: _____ City:_____ State:_____ Zip:_____

Phone #:_____

Name of Parent/Guardian: _____

I authorize my health care provider and local public health agency to collect and enter my child's immunization records into the Department of Public Health and Human Services' Immunization Information System (IIS/imMTrax). ImMTrax is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to local health departments as well as my health care providers to assist in my child's medical care and treatment. In addition, information may be released to child care facilities and schools in which my child is enrolled to comply with state requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local county health department.

Parent/Guardian Signature:_____ Date:_____

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Parent/Guardian Signature:_____ Date:_____

IZ Consent –101 (09/26/2011)